_	State of New Jersey					(De	D NOT FILL IN)		
	Department of Labor Division of Workers' Compensation EMPLOYEE'S				ETITION	CASE No.			
	PO Box 381 Trenton, New Jersey 08625-038					D.O			
P E	SOCIAL SECURITY NUMBER		_ O NEW JERSEY				☐ FEDERAL EMPLOYER ID NUMBER		
			A T	P	REGISTRATION N	IUMBER			
T	NAME		C	Э Т	 		,		
Ť	ADDRESS (Including County)		l N	RI	ADDRESS				
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	ZIP CODE VS			N E	ADDRESS				
•				R	TELEPHONE (Area Code)				
R	NAME	· · · · · · · · · · · · · · · · · · ·	ı		NAME (indicate it blo	Covered or self-insured)	····		
E S	IAVWE			1	NAME (INGICATE IT NO	Covered of sell-insured)			
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E N	ZIP CODE	:	Ą	λÏ					
T			, C		ZIP CODE	15.1111050			
					CARRIER'S CLAIM FI	LE NUMBEH			
em	THE DIVISION OF WORKE Petitioner, alleging that P ployment with Respondent, of	etitioner sustained an inju		et se					
	Occupational Exposure Dates of Exp	posure							
How	Injury Occurred								
Occ	upation		Dat	te Sto	pped Work		Date Returned to Work		
Sex	Date of Birth	Marital Status	Dat	te Inju	ıry Reported To Em	mployer and To Whom			
Gro:	ss Weekly Wages	Rate of Compensation	.,	Ţ	emporary Disability	Paid	Permanent Disability Paid		
<u> </u>	SCRIBE EXTENT AND CHAP		ere has	• s be∉	en amoutation	or disability to an	v member or impairment		
	ny physical function, explain				•	•			
_									
	dical aid (WAS) (WAS NOT)	iurnished by Petitioner's em	nlover						
	e names and addresses of phy		pioyei.						
	Demand is hereby made for	answers to standard occupa	ational	dise	ase interrogator	ries.			
	Demand is hereby made for	all records of medical treatr	nent, e	xami	nations and dia	gnostic studies.			
WE	RE YOU ELIGIBLE FOR MED	DICAID BENEFITS AT THE	TIME O	F TI	HE ACCIDENT	P D YES D NO)		
DIE	YOU BECOME ELIGIBLE FO	OR MEDICAID BENEFITS A	FTER	THE	ACCIDENT?	TYES INC)		
	U ARE ADVISED THAT MEDIC TH N.J.S.A. 30:4D-1, ET SEQ.		וו טו ט	nt A	ACCIDENT ARE	: 10 BE REPAID	IN ACCORDANCE		

In occupational disease	claims, list o	claims against	other	employers	filed or	to be	filed for	the same	or similar
occupational diseases.				1					

NAME & ADDRESS OF EMPLOYER

DATES OF EMPLOYMENT

Your Petitioner therefore requests that the Division of Workers' Compensation determine the amount of compensation due your Petitioner from said Respondent, under Revised Statutes of New Jersey, Title 34, Chapter 15, and the Acts supplemental thereto and amendatory thereof, and that your Petitioner may be awarded Petitioner's costs in this proceeding, and such other or further relief as may be proper.

(Petitioner)	

STATE OF NEW JERSEY COUNTY OF

Subscribed and sworn or affirmed to before me this day of

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Please be advised that information collected from the filing of this claim petition may be used by the Division of Workers' Compensation for record keeping, record access/distribution, and case scheduling purposes. Petitions filed with the Division are public documents and may be inspected and copied except where prohibited by Section 34:15-128 of the Workers' Compensation statute.

The foregoing Claim Petition has been presented by the Petitioner to the Division of Workers' Compensation for hearing and determination. Unless an Answer is filed within 30 days of the date of service of the Claim Petition upon you, with the assignment clerk at the office to which the claim is assigned as indicated on the reverse side, and a copy served upon the Petitioner's attorney, THE PETITIONER WILL PROCEED WITH PROOF OF CLAIM ACCORDING TO LAW AND MAY OBTAIN JUDGMENT AGAINST YOU.

The Privacy Act, 5 U.S.C. § 552a, the Social Security Act, 42 U.S.C. § 405, and *N.J.S.A.* 34:15-1 *et seq.* authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.